

information that the QIC needs to make its expedited reconsideration as soon as possible, but no later than by close of business of the day that the QIC notifies the QIO of the request for an expedited reconsideration.

(2) At a beneficiary's request, the QIO must furnish the beneficiary with a copy of, or access to, any documentation that it sends to the QIC. The QIO may charge the beneficiary a reasonable amount to cover the costs of duplicating the documentation and/or delivering it to the beneficiary. The QIO must accommodate the request by no later than close of business of the first day after the material is requested.

(e) *Responsibilities of the provider.* A provider may, but is not required to, submit evidence to be considered by a QIC in making its decision. If a provider fails to comply with a QIC's request for additional information beyond that furnished to the QIO for purposes of the expedited determination, the QIC makes its reconsideration decision based on the information available.

(f) *Coverage during QIC reconsideration process.* When a beneficiary requests an expedited reconsideration in accordance with the deadline specified in (b)(1) of this section, the provider may not bill the beneficiary for any disputed services until the QIC makes its determination.

**§ 405.1205 Notifying beneficiaries of hospital discharge appeal rights.**

(a) *Applicability and scope.* (1) For purposes of §§ 405.1204, 405.1205, 405.1206, and 405.1208, the term "hospital" is defined as any facility providing care at the inpatient hospital level, whether that care is short term or long term, acute or non acute, paid through a prospective payment system or other reimbursement basis, limited to specialty care or providing a broader spectrum of services. This definition includes critical access hospitals.

(2) For purposes of §§ 405.1204, 405.1205, 405.1206, and 405.1208, a discharge is a formal release of a beneficiary from an inpatient hospital.

(b) *Advance written notice of hospital discharge rights.* For all Medicare beneficiaries, hospitals must deliver valid, written notice of a beneficiary's rights

as a hospital inpatient, including discharge appeal rights. The hospital must use a standardized notice, as specified by CMS, in accordance with the following procedures:

(1) *Timing of notice.* The hospital must provide the notice at or near admission, but no later than 2 calendar days following the beneficiary's admission to the hospital.

(2) *Content of the notice.* The notice must include the following information:

(i) The beneficiary's rights as a hospital inpatient including the right to benefits for inpatient services and for post-hospital services in accordance with 1866(a)(1)(M) of the Act.

(ii) The beneficiary's right to request an expedited determination of the discharge decision including a description of the process under § 405.1206, and the availability of other appeals processes if the beneficiary fails to meet the deadline for an expedited determination.

(iii) The circumstances under which a beneficiary will or will not be liable for charges for continued stay in the hospital in accordance with 1866(a)(1)(M) of the Act.

(iv) A beneficiary's right to receive additional detailed information in accordance with § 405.1206(e).

(v) Any other information required by CMS.

(3) *When delivery of the notice is valid.* Delivery of the written notice of rights described in this section is valid if—

(i) The beneficiary (or the beneficiary's representative) has signed and dated the notice to indicate that he or she has received the notice and can comprehend its contents, except as provided in paragraph (b)(4) of this section; and

(ii) The notice is delivered in accordance with paragraph (b)(1) of this section and contains all the elements described in paragraph (b)(2) of this section.

(4) *If a beneficiary refuses to sign the notice.* The hospital may annotate its notice to indicate the refusal, and the date of refusal is considered the date of receipt of the notice.

(c) *Follow up notification.* (1) The hospital must present a copy of the signed notice described in paragraph (b)(2) of

this section to the beneficiary (or beneficiary's representative) prior to discharge. The notice should be given as far in advance of discharge as possible, but not more than 2 calendar days before discharge.

(2) Follow up notification is not required if the notice required under § 405.1205(b) is delivered within 2 calendar days of discharge.

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**§ 405.1206 Expedited determination procedures for inpatient hospital care.**

(a) *Beneficiary's right to an expedited determination by the QIO.* A beneficiary has a right to request an expedited determination by the QIO when a hospital (acting directly or through its utilization review committee), with physician concurrence, determines that inpatient care is no longer necessary.

(b) *Requesting an expedited determination.* (1) A beneficiary who wishes to exercise the right to an expedited determination must submit a request to the QIO that has an agreement with the hospital as specified in § 476.78 of this chapter. The request must be made no later than the day of discharge and may be in writing or by telephone.

(2) The beneficiary, or his or her representative, upon request by the QIO, must be available to discuss the case.

(3) The beneficiary may, but is not required to, submit written evidence to be considered by a QIO in making its decision.

(4) A beneficiary who makes a timely request for an expedited QIO review in accordance with paragraph (b)(1) of this section is subject to the financial liability protections under paragraphs (f)(1) and (f)(2) of this section, as applicable.

(5) A beneficiary who fails to make a timely request for an expedited determination by a QIO, as described in paragraph (b)(1) of this section, and remains in the hospital without coverage, still may request an expedited QIO determination at any time during the hospitalization. The QIO will issue a decision in accordance with paragraph (d)(6)(ii) of this section, however, the financial liability protection under paragraphs (f)(1) and (f)(2) of this section does not apply.

(6) A beneficiary who fails to make a timely request for an expedited determination in accordance with paragraph (b)(1) of this section, and who is no longer an inpatient in the hospital, may request QIO review within 30 calendar days after the date of discharge, or at any time for good cause. The QIO will issue a decision in accordance with paragraph (d)(6)(iii) of this section; however, the financial liability protection under paragraphs (f)(1) and (f)(2) of this section does not apply.

(c) *Burden of proof.* When a beneficiary (or his or her representative, if applicable) requests an expedited determination by a QIO, the burden of proof rests with the hospital to demonstrate that discharge is the correct decision, either on the basis of medical necessity, or based on other Medicare coverage policies. Consistent with paragraph (e)(2) of this section, the hospital should supply any and all information that a QIO requires to sustain the hospital's discharge determination.

(d) *Procedures the QIO must follow.* (1) When the QIO receives the request for an expedited determination under paragraph (b)(1) of this section, it must immediately notify the hospital that a request for an expedited determination has been made.

(2) The QIO determines whether the hospital delivered valid notice consistent with § 405.1205(b)(3).

(3) The QIO examines the medical and other records that pertain to the services in dispute.

(4) The QIO must solicit the views of the beneficiary (or the beneficiary's representative) who requested the expedited determination.

(5) The QIO must provide an opportunity for the hospital to explain why the discharge is appropriate.

(6)(i) When the beneficiary requests an expedited determination in accordance with paragraph (b)(1) of this section, the QIO must make a determination and notify the beneficiary, the hospital, and physician of its determination within one calendar day after it receives all requested pertinent information.

(ii) When the beneficiary makes an untimely request for an expedited determination, and remains in the hospital, consistent with paragraph (b)(5)